OFFICIAL

7-19-A

79-16

REQUEST FOR APPROVAL OF THE PROSPECTIVE REIMBURSEMENT PROGRAM IN THE STATE OF RHODE ISLAND UNDER SECTION 232 OF P.L. 92-603 BY THE SINGLE STATE AGENCY BEGINNING OCTOBER 1, 1979

Department of Social and Rehabilitative Services,
Division of Medical Standards and Review
and
Department of Administration, Division of Budget
State of Rhode Island
State House
Providence, Rhode Island 02903

July, 1979

A

OFFICIAL

SECTION A - PART I HISTORY AND BACKGROUND

Rhode Island has had considerable experience with the concept of prospective reimbursement. The first program of its kind in the country was implemented in Rhode Island in 1971. Three years later, the Social Security Administration funded a three-year prospective reimbursement program which began on October 1, 1974 and will end on September 30, 1977. During that time, the provisions of the Rhode Island program have been reviewed, evaluated, changed and refined. It is safe to say that the participants in the Rhode Island program have had the longest experience with the mechanism of prospective reimbursement of anywhere in the country and have developed many knowledgeable insights into the practical application and workability of prospective reimbursement.

Within the past several years, there has been an intensified interest and concern in the rising costs of health care in this country, particularly since those costs continue to outpace the rest of the economy. The Federal government has recently attempted to confront the health care cost spiral through coordination of health planning and, more recently, the implementation of cost controls or limits through Federal health care programs such as Medicare. In addition, state and local communities have been encouraged by the Federal government to apply cost control measures to the health care industry. In an equally concerned response, some state governments have established rate setting commissions to review and approve hospital rates. Among these are Connecticut, New Jersey, Massachusetts, and Maryland. States such as Rhode Island and New York have passed legislation dealing with the problem of hospital costs. These approaches to cost containment are varied and are being

met with varied degrees of success. However, it is clear that appropriate methods to moderate and contain health care costs in this country must be found. Our health care resources are no longer limitless even though the demand for health care services continues to grow. The health care system, as well as other segments of our economy, e.g. energy, education, is finding itself in the classic economic dilemma of trying to meet those growing and seemingly unlimited demands within the confines of limited resources.

The State of Rhode Island and the voluntary sector (Blue Cross and the hospitals) have taken action to confront this problem in a cooperative setting. In 1971, this community embarked on a prospective reimbursement program, abandoning the old retrospective cost reimbursement system. This program has gone through several major changes since 1971; and under a contract from the Social Security Administration, Blue Cross, the State, and all sixteen voluntary hospitals are now in the third year of a prospective reimbursement program. The following will describe that system in Rhode Island, the responsibilities of its participants, and the experience to date.

Prospective Reimbursement in Rhode Island (1970-72).

Like the rest of the nation, hospital costs in Rhode Island after the introduction of Medicare turned sharply upward. While there is some dispute about the actual percentages, it is agreed that overall operational costs in Rhode Island hospitals rose between 15 and 20 percent per year between 1967 and the introduction of prospective rate setting.

Right after Medicare, Rhode Island Blue Cross found itself with an excellent reserve position due to the provision of benefits to the elderly by Medicare. Taking advantage of this situation, the Plan made selected benefit improvements to fill

weaknesses in its basic contracts and to encourage use of outpatient rather than costly inpatient services.

A combination of soaring costs and improved benefits soon turned the financial situation around, forcing the Plan to file for sizable rate increases three years in a row.

The state director of business regulation, required by Rhode Island state law to pass on the "reasonableness" of Blue Cross rates, reacted with increasing alarm to each subsequent rate increase filing. Blue Cross took the position that rising premium rates were merely symptoms of the real problem, that is, rising hospital costs, and that hospitals, therefore, should be parties to Blue Cross filings and should testify at rate hearings.

After extended hearings in 1969 (for 1970 rates) during which hospitals were asked to testify, the department took the position that a major culprit in the cost spiral was the "open-ended cost reimbursement contract." The director essentially "ordered" hospitals and the Plan to overhaul the reimbursement system so as to build in cost ceilings and incentives for savings, if not to discard the present system altogether.

It was against this background that the prospective rating program in Rhode Island evolved:

1. Rhode Island Hospital, the largest hospital in the state, negotiated a prospective reimbursement contract for fiscal 1970-1971 on a pilot test basis.
2. All other hospitals agreed to a decrease in the requested amounts and to "guarantee their budgets" during the same fiscal year.
3. All hospitals were allowed to keep 50% of any savings, and had to absorb any losses.

4. All hospitals negotiated prospective reimbursement contracts in fiscal 1971-1972. Rhode Island hospitals were given a class exception from Phase II price controls to permit the experiment.
5. At the end of fiscal year one, 9/30/71, actual hospital expenditure experience, when looked at collectively, was under budget for the first time in four years.
6. At the start of year two, 10/1/71, budgets were reduced by some $6,500,000. This would have resulted in a ten percent increase in the per diem rate.
7. Areawide planning came into play as hospitals deferred, altered or abandoned program plans that did not receive approval by the medical program review mechanism.

Planning Agency Participation. One of the most important benefits of Prospective Rate Setting in Rhode Island was the creation of a medical program review mechanism, particularly in view of the proliferation of new laboratories, techniques and equipment. Blue Cross and the hospitals established a special procedure for screening hospital proposals for new or expanded services which would require Blue Cross reimbursement prior to submission as part of the budget negotiation process.

The medical program review process had particularly important community planning implications. The Health Planning Council, Inc., a nonprofit organization with a broadly representative community Board of Trustees, establishes priorities for Blue Cross reimbursement and reviews hospitals' proposals in terms of overall community needs and ability to pay, rather than solely in terms of their technical worth. Review is conducted at an early stage in the hospital's planning process, before new project ideas are translated into detailed formal proposals.

In conjunction with the medical program review requirements, the Rhode Island Department of Health had the authority to approve or reject requests for construction (or modernization) in excess of $200,000 and for purchase of new equipment above

$50,000. The Health Department also had licensing and franchising control. Hospitals were also required to submit long and short range plans for services development and maintenance on an annual basis.

The State Budget Office. In July, 1971, an act of the General Assembly of Rhode Island mandated that the state, through the Budget Officer, would be a party to budget negotiations held for the purpose of determining payment rates for hospital costs by the state. The law provided for review of agreed upon budgets and related statistics at least 30 days prior to the beginning of each fiscal year. Once the Budget Officer had reached agreement with the hospitals and Blue Cross, that agreement was considered prima facie evidence that the budgets are "reasonable as a component of rates paid by the state as a purchaser of hospital services," and as a component of any premium rate filings by Blue Cross.

Prior to 1971, the control effected by the state over hospital costs was essentially indirect--through its responsibility in the Department of Business Regulation for approving rate changes requested by Blue Cross. Now the State was legislatively imposed into the process and hospital budgets could not be finalized without the direct participation of the State Budget Officer in negotiations.

Up until FY 1972/73, Rhode Island received a waiver from the Economic Stabilization Program (ESP) which had allowed it to operate under the Prospective Reimbursement Program. However, when ESP entered Phase III, it was realized by the parties that the prospective reimbursement system was not consistent with ESP controls, and the program was suspended.

Program Results. There is some disagreement regarding the effectiveness of this early program in controlling hospital costs. However, the parties did and still

do feel that the program was a significant improvement over the former retrospective reimbursement system. In addition, the program brought cost control savings and a cost containment awareness to the State that had not existed prior to this time. For example:

1. For FY 1971, actual hospital expenditure experience when looked at collectively, was under budget for the first time in four (4) years.
2. At the start of the second year, hospital budgets were reduced by some $6.5M which resulted in only a ten percent (10%) increase in the per diem rate.
3. Areawide planning for medical programs was introduced.
4. The educational experience for all participants, providers and purchasers was considered invaluable and would aid the parties to better contain hospital costs in the future.

For FY 1974/75 the parties again embarked on a cost containment program for the State. Subsequent to negotiations with the Social Security Administration, Rhode Island's Prospective Reimbursement Program received a contract under Sec. 222 of PL 92-603 for a three-year experiment in cost containment and a waiver of the Medicare cost limitations under Sec. 223. The experimental contract began October 1, 1974 and extends to September 30, 1977. The present program has now entered its third year.

The following is a description of the program which has been supported by the Social Security Administration for the past three years and forms the basis for the operation of the 1977-78 program.

A. PROGRAM OVERVIEW

Like the earlier Prospective Reimbursement Program, the present program's participants are the Budget Office of the State of Rhode Island, Blue Cross of Rhode Island, the Hospital Association of Rhode Island, and the Association's

participating sixteen voluntary hospitals.

The State Budget Office represents the State's interests as purchasers of health care through Medicaid, Title V, the Department of Vocational and Rehabilitative Services and General Public Assistance, as well as the interests of the general population of Rhode Island. The parties are operating under a three-year contract between the third parties and the sixteen hospitals. For Blue Cross, the contract is an amendment to the basic hospital contract for fifteen participating hospitals and a separate contract with one non-participating institution. A separate contract exists between each hospital and the State.

Basic Objectives

The program's basic objectives are:

1. Contain costs;
2. Assure growth in programs is based on statewide need;
3. Shift health resources away from inpatient care modalities;
4. Reward management efficiencies and improve productivity; and
5. Ensure that cost control efforts do not have a deleterious effect on patient care.

Basic Features

The basic features of the present program include:

1. A limit on total allowable operating expense increases on a statewide basis (a MAXICAP). (The first such total expenditures limitation concept in the country.)

2. Submission of new and expanded medical programs to a planning, review, and advisory process prior to budget negotiations. Capital programs must also be reviewed under the State's certificate of need legislation.
3. After internal review and analysis by Blue Cross and the State Budget Office, each hospital budget (both total expenses and statistical volumes) is then negotiated with that hospital. The participants in that budget negotiation are the State Budget Office, Blue Cross and the affected hospital. No Budget can be settled through negotiations unless there is unanimous consent by all the parties.
4. Rates are set on the basis of the ratio of lower of costs or charges and according to each third party payer's reimbursement principles, after the budget has been negotiated and the final budget has been submitted to cost finding. Hospitals also agree to guarantee their charge structures as determined for the budget fiscal year.
5. Provisions are made to reimburse the hospitals for any unusual and unexpected increases in volume that may occur, as well as other major unforeseen and unpredictable expenses (major contingencies).

All of this activity is aimed at controlling the overall increases in hospital costs and yet provide sufficient flexibility within the overall dollar controls to permit hospitals to utilize their dollars to provide planned services and programs and improve the quality of care to their patients. Also, hospitals are provided incentives for management efficiencies and improved productivity. On a broader, statewide scale, the program is designed to contain the growing cost spiral of health care in Rhode Island and provide an effective, rational method of allocating and redistributing the State's ever-diminishing health care resources to meet the ever-growing needs and demands

of the community. Above all, it has been and is still the intent of all the program participants to do this within a cooperative environment and demonstrate that the State law can be effectively carried out through a contractual arrangement among the parties.

B. EXPLANATION OF BASIC FEATURES OF THE PROGRAM

1. Statewide MAXICAP

The most significant feature of the Rhode Island Program is the state-wide MAXICAP. The MAXICAP is an outside budget limitation on the aggregate gross operating expenses of the voluntary hospitals in Rhode Island for a fiscal year, excluding expenses associated with professional components (i.e. Medicare, Part B) and activities financed by grants and contracts. These latter two categories of expenses are not directly controlled under the program. It must be stressed that the MAXICAP is not a target for expenses, but is a ceiling or outside limitation within which all hospital budgets must be negotiated and a reserve maintained for unforeseen expenses during the fiscal year. This does not mean that each hospital is given an across-the-board increase equal to the MAXICAP. The parties are free to negotiate hospital budgets above or below the limit of the CAP. However, in the aggregate when budget negotiations are complete, the MAXICAP shall not be exceeded. The goal is to maintain a ceiling on total expenses while providing the flexibility to recognize problems, programmatic development, unusual circumstances, etc. at a given institution.

Each spring, prior to the beginning of the next fiscal year and individual hospital budget negotiations, a committee of representatives of the State Budget Office, Blue Cross, and the Hospital Association of Rhode Island (HARI) (representing its sixteen member hospitals) meets to negotiate the MAXICAP.